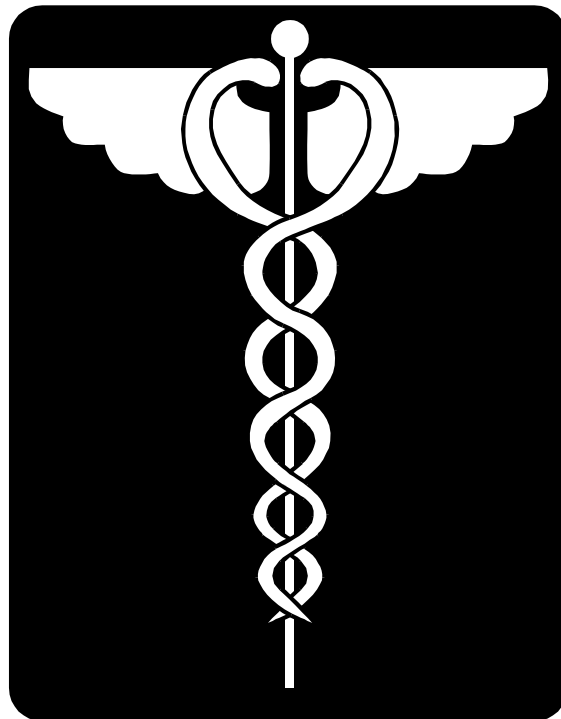


**2003 Statewide Medical & Health
Disaster Exercise**

EXERCISE GUIDEBOOK

State of California
Emergency Medical Services Authority



NOVEMBER 13, 2003



**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003**

Executive Summary

Dear Exercise Participant:

It is time again for the Statewide Medical & Health Disaster Exercise! This is California's fifth annual exercise incorporating hospitals and other healthcare providers, including long-term care facilities and clinics, pre-hospital care providers, auxiliary communication networks, blood banks and local and regional governmental agencies. This year, we are inviting and encouraging local public health departments to participate in this biological terrorism exercise.

The last couple of years, the exercise has focused on "man-made" disasters that confront emergency managers and the healthcare community. This year, the Exercise Planning Committee has designed the scenario to include issues and challenges that would confront the State should a biological terrorism event occur in California.

In evaluating the 2002 Statewide Medical & Health Disaster Exercise, participants were asked about conducting the exercise in "off hours." Approximately 83% of respondents replied that their facilities would be interested in an "off hours" exercise and 72% responded that the p.m. shift hours are a number one priority. Therefore, the Exercise Planning Committee planned this year's exercise for the p.m. shift hours.

An "off hours" exercise may pose unique planning issues at the participant and local level. The Operational Area (county) Exercise Contact is your point of contact for planning, questions and organization for the exercise. We encourage you to contact the Operational Area Exercise Contact early in the planning process to assist you in the execution of the 2003 exercise. Please see page 42 of this guidebook for the listing of Exercise Contacts.

Important Timelines and Deadlines

<u>August 20, 2003</u>	Operational Area Exercise Contact Orientation Conference Call from 2:00 p.m. until 4:30 p.m. The call is intended to orient the Exercise Contacts to the exercise and assist with organization and planning for the exercise. Exercise Contacts will be notified of the conference call-in numbers.
<u>September 10, 2003</u>	Deadline to fax Intent to Participate Form (page 18) to the Operational Area Medical/Health Exercise Contact (see list of contacts on page 42).
<u>September 26, 2003</u>	Deadline for Operational Area Exercise Contacts to fax the OA Intent to Participate Form to the Regional Disaster Medical/Health Specialist (see list on page 47)
<u>November 13, 2003</u>	The exercise will be conducted from 1600 (4:00 p.m.) until 2000 (8:00 p.m.) The scenario stages the exposure event to occur on Monday, November 10, 2003, and the healthcare system responds to overwhelming numbers of patients presenting with symptoms, building up to the beginning of the exercise.
<u>November 28, 2003</u>	Deadline to complete and mail the appropriate Master Answer Sheet (page 20, 24 or 28) to the California Emergency Medical Services Authority (see address on form) to receive a participation certificate.

**Thank you for your commitment to disaster medical planning and preparedness.
We look forward to hearing about your successful exercise!**



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EXERCISE OBJECTIVES

Hospital Objectives

Pre-Exercise Event: [Joint Commission on Accreditation of Healthcare Organizations (JCAHO) EC 1.4 (d) and Title 22 70741(b)]

Assess the facility's integration and participation in community-wide emergency preparedness, planning and response. This integration includes area hospitals, public health, public and private emergency medical services (EMS) providers, law enforcement and emergency managers. As a result of this assessment, create collaboration and relationships with important providers to prepare for the exercise and any actual event.

Objective I: [JCAHO EC 1.4 (b) and EC 2.9.1]

Implement the facility's emergency preparedness response plan using a recognized incident command system (preferably the Hospital Emergency Incident Command System, or HEICS). Participation in this exercise meets the California Title 22, 70741(d) and JCAHO EC 2.9.1. The disaster plan must be exercised at least twice per year.

Objective II:

Assess internal pharmaceutical capabilities to provide treatment and/or prophylaxis for current patients, staff and staff families for a minimum of 72 hours.

Objective III: [JCAHO EC 1.4 (c, d)]

Assess the status of your facility and communicate that status to appropriate governmental agencies within the operational area, utilizing hospital communication systems, if applicable.

Objective IV: [JCAHO EC 1.4 (n)]

Assess the ability to respond to a public health emergency due to a biological terrorism event, including proper infection control procedures and isolation of infectious patients.

Objective V: [JCAHO EC 1.4 (c, d, m)]

Implement alternate communication systems to contact public/private medical and health officials, including local government, "sister" and other supportive area facilities or hospitals.

Objective VI: [JCAHO EC 1.4 (h, i, j)]

Assess the response capability of managing an influx of patients, inpatient bed overcrowding, cohorting of infectious patients and management of scarce resources.

Objective VII:

Develop risk communication messages consistent with local authorities in a rapid and timely manner for internal and external dissemination.

Objective VIII:

Assess the ability of your facility to communicate the identified threats and appropriate actions to hospital staff and staff families.

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EXERCISE OBJECTIVES

Ancillary Healthcare Facility Objectives (Includes skilled nursing, long-term care, psychiatric and clinic facilities)

Objective I:

Implement the facility's emergency preparedness response plan, preferably using a recognized incident command-based system.

Objective II:

Assess the status of your facility and communicate that status to appropriate governmental agencies within the operational area, utilizing appropriate communication systems, if applicable.

Objective III: Assess the ability of your facility to appropriately clear occupied beds and increase bed capacity to accept acute care hospital transfers during this public health crisis.

Ambulance Objectives

Objective I:

Implement the provider's emergency preparedness response plan using a recognized incident command system.

Objective II:

Assess the status of your facility and communicate that status to appropriate governmental agencies within the operational area, utilizing appropriate communication systems, if applicable.

Objective III:

Assess the ability to manage transportation of infectious patients due to a biological terrorism event, including infection control measures for EMS personnel and vehicles and the coordination of patient transportation destinations with healthcare facilities and local public health.

Objective IV:

Utilize alternative communication systems to reach local government medical and health contacts, including dispatch and local area hospitals.

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EXERCISE OBJECTIVES

Auxiliary Communications Systems (ACS) Objectives

Objective I: (Pre-Exercise)

Coordinate with local auxiliary communications radio operators on frequencies, protocols and forms used during an exercise/actual event.

Objective II:

Test regional/statewide Auxiliary Communication Systems (ACS) and redundant communications in coordination with local amateur radio operators, using established frequencies, protocols and data collection/reporting forms.

Objective III:

Pass two-way communication messages between state, regional and operational area providers.

Operational Area Emergency Operations Center and Exercise Contact

Objective I:

Assess the Operational Area's ability to collect timely, accurate and appropriate data from participants.

Objective II:

Implement Emergency Operations Center's procedures and mechanisms for managing a biological terrorism event, including the procurement, management and allocation of scarce resources within the Operational Area.

Objective III:

Demonstrate the ability to access, enter data into and transmit Response Information Management System (RIMS) data to regional and state medical and health authorities.

Objective IV:

Activate auxiliary communications systems and pass two-way messages to regional and state providers.

Objective V:

Develop risk communication messages consistent with local public health and hospitals in a rapid and timely manner for internal and external dissemination.

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EXERCISE OBJECTIVES

Local Public Health Departments

Objective I:

Assess the department's ability to communicate threats and health alerts to healthcare providers, including hospitals, clinics, EMS providers and others.

Objective II:

Develop risk communication messages consistent with local emergency managers, hospitals and other officials in a rapid and timely manner for internal and external dissemination.

Objective III:

Assess the local public health surveillance, epidemiology and contact tracing during this biological terrorism event.

Objective IV:

Demonstrate the ability to access and transmit information to region and state medical and health authorities through RIMS and CAHAN.

State Agencies

Objective I:

Coordinate with the Operational Area and regions for resource requests.

Objective II:

Demonstrate the ability to access and transmit information to region and state medical and health authorities through RIMS and/or the California Health Alert Network (CAHAN).

Objective III:

Develop risk communication messages consistent with local public health, healthcare agencies and other local/regional officials in a rapid and timely manner for internal and external dissemination.

Objective IV:

Assess the process for and ability to order the Strategic National Stockpile (formerly the National Pharmaceutical Stockpile).



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BACKGROUND FOR THE SCENARIO

NOTE: The Statewide Medical and Health Disaster Exercise begins on November 13, 2003, at 4:00 p.m. This information is provided as scenario background to “set the stage” for the events leading up to the day of the exercise. The intention of the scenario is that the community is faced with a growing medical and health crisis. When the exercise begins, participants must manage the surge capacity and make decisions on the utilization of scarce resources.

November 2003

11-10-03 On Monday evening at 7:00 p.m., there is a free concert that had been planned for months. The event coordinators and sponsors anticipated large numbers of attendees from within and outside of the community. Indeed, the venue was filled to capacity with young and old alike enjoying the fall concert. The event was held indoors in a large building (e.g., gymnasium, arena, enclosed stadium or armory) within the community.

At the end of the event, the cleaning crew finds some devices that look like oxygen tanks near three of the return air vents within the venue. One of the three was still spraying a fine mist into the vent. The device looked “homemade” and none of the cleaning crew knew what the canister was or why it was near the vents.

In their hurry to complete the cleaning of the venue and return home for the night, they placed the canisters in a plastic bag and set them aside. They decided to discuss the canisters with the venue manager on Tuesday morning. The cleaning crew left the venue at 12:30 a.m.

11-11-03 Tuesday morning at 9:00 a.m., the cleaning crew arrives at work. They take the canisters to the venue manager and inform him that they found these canisters next to the return air vents at about 11:00 p.m. the night before. The manager opens the plastic bag containing the canisters and examines them thoroughly. They indeed look “homemade” but harmless to him. Nonetheless, he decides to contact the local law enforcement agency to report the canisters and the event.

11-11-03 Local law enforcement arrives at the venue at 11:00 a.m. to investigate the report from the venue manager, and suspecting foul play, immediately contacts the team within his jurisdiction to respond to a hazardous materials incident.

The haz mat team arrives and contains the canisters safely. Local public health is contacted to assist with examining the canisters and identifying any possible hazard. Samples from the canisters are obtained and sent to the state public health laboratory for analysis. The decision is made to keep this information secure until an agent, if any, can be identified.

BACKGROUND FOR THE SCENARIO

November 2003

11-12-03 A 47-year old female, Jane, a heavy smoker, presents at the hospital emergency department at 6:30 a.m. complaining of a fever (103°F), shortness of breath and malaise. The patient reports a history of chest pain and cough since Tuesday, November 11. Chest x-ray shows patchy bilateral infiltrates and consolidation. Hemoptysis develops. Lab studies, including blood and sputum cultures, are obtained and antibiotics are started. By noon, her condition deteriorates and she is intubated and placed on mechanical ventilation.

11-12-03 As the day progresses, a large number of patients present to the hospital complaining of high fever, headache, muscle pains, chills and malaise. Emergency Medical Services responders are also reporting an increase in the volume of 911 calls over the last 24 hours.

In the hospital, after triage and treatment, patients with mild symptoms are discharged to home with a working diagnosis of influenza. They are provided symptomatic care instructions to rest and increase their fluid intake, asked to follow up with their private physician in 48 hours if their condition has not improved and asked to return to the emergency department if symptoms worsen. Eight patients with more severe symptoms are admitted to the hospital for care. Two of the patients admitted with severe symptoms requiring intubation are employed as part of the cleaning crew in the local venue.

The hospitals within the county are all reporting high census in the emergency departments and an increased number of inpatient admits with respiratory symptoms. Many hospitals in the area have gone on and off diversion (for emergency department saturation and high inpatient census) frequently in the last 24 hours.

The hospitals contact the Local Public Health Department to report a number of influenza-like cases presenting to the hospitals. Local public health initiates an investigation of the cases and during the contact tracing and history, trace all patients presenting with severe symptoms as having attended the concert on Sunday evening. Local public health contacts the State laboratory to expedite analysis of the agent in the canisters found at the venue on Sunday.

11-12-03 The State laboratory notifies the local health officer at 2:00 p.m. that the agent found in the canisters sent for analysis contained *Yersinia pestis*. The local public health epidemiological investigation and contact tracing confirms that the patients all attended the free concert on Sunday. A local public health emergency is declared and the California Department of Health Services (CDHS) is notified of the emergency. Hospitals, clinics, EMS providers and other healthcare agencies are notified by local public health or designated agency.

11-12-03 As the day progresses, nearly 250 patients with flu-like symptoms have been seen in the emergency departments in the area, and 911 calls in the area continue to increase. Emergency Operations Centers (EOC) open in the county, and local public health is the lead agency. The hospitals activate HEICS, including activation of the hospital EOC. Strict infection control measures are instituted, including respiratory and droplet protection with the N-95 Mask and protective clothing.

BACKGROUND FOR THE SCENARIO

November 2003

11-12-03 Local media hear “rumors” at 6:00 p.m. about a terrorism incident and that many people are becoming ill. They have been monitoring emergency scanners and hear that the EMS calls have been increasing. Media begin to contact hospitals, clinics and other public officials for information. The media announce that there is an event going on in the community and public anxiety increases. Many healthcare providers are calling their employer to express their anxiety about coming to work and being exposed to the disease.

11-12-03 In the hospital, Jane, the heavy smoker who presented to the hospital on November 12, arrests at 9:00 p.m. and efforts to revive her are unsuccessful. She is pronounced dead at 9:02 pm. Her family is distraught and talks to the media upon leaving the facility.

Hospitals and clinics are overwhelmed with large numbers of patients reporting for evaluation and care. Across the county, patients present with flu-like symptoms. The hospitalized patients have developed severe pneumonias, shortness of breath and hemoptysis, and many are requiring intubation. Hospitals are reporting bed availability and requests for additional antibiotics and staffing. The hospitals are reporting numbers of patients being intubated and requiring mechanical ventilation, being treated and released, being treated and admitted and numerous deceased.

Clinics and medical offices are referring the more ill patients to the emergency departments for evaluation and are referring outpatients to the x-ray departments for services. The inpatient census has reached capacity. Respiratory therapy is overwhelmed with requests for respiratory treatments for inpatients and outpatients. There is a shortage of admission beds across the county. The hospital contacts the county EOC for assistance and possible transfer of patients.

The local public health departments activate the mass prophylaxis plan for the community. Multimedia health alerts recommend the following groups of people to present to the mass prophylaxis clinics:

- Those in contact with people who attended the free concert on Sunday and do not have any fever, cough or illness.
- Those who attended the free concert and do not have any fever, cough or illness.

Prophylaxis for pneumonic plague is doxycycline for a seven-day course. Alternative therapy is tetracycline or chloramphenicol. Local public health medication supplies for mass prophylaxis are anticipated to be exhausted by November 14 at noon.

11-13-03 EMS providers report at 6:00 a.m. that they are saturated with 911 calls with a chief complaint of high fever, headache, malaise and cough. Many 911 calls are from the “worried well” asking for information on the “severe flu” as the media have coined it.

BACKGROUND FOR THE SCENARIO

November 2003

11-13-03 Hospitals are reporting at 11:00 a.m. that the high census and lack of resources, including staff, beds, medications and durable medical equipment, especially ventilators, have reached a critical level and assistance is needed.

Many of the hospital and clinic staff have called in sick for their shifts, complicating the resource situation. High census plans are activated in the hospitals and all patients that can be discharged or transferred to alternate care facilities are moved. Negative pressure isolation rooms' capacities are inadequate to meet the patient load. Strict respiratory and droplet isolation is instituted in the facility. There have been 25 deaths reported at this time, and the coroner has been notified to perform autopsies to determine causes of death.

11-13-03 Media from across the state and nation are reporting the biological terrorism event at 2:00 p.m. There are reports from neighboring county health departments that similar cases are being reported in emergency departments and clinics, and strict isolation of the patients is being instituted. The media are arriving at hospitals, clinics, local health departments and governmental agencies demanding information.

Businesses across the local area report high absenteeism because people are afraid to leave their homes. Community alerts are being broadcast on radio and television to provide accurate information to the public.



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EXERCISE DAY SCENARIO
"The Exercise Begins!"
November 13, 2003
4:00 PM UNTIL 8:00 PM

Note: The exercise begins with the events listed in the background information in the previous section leading up to this point. Participants may recreate the background events and organization status when beginning the exercise to increase realism into the exercise play.

4:00 p.m. THE EXERCISE BEGINS

The Operational Area (OA) is reporting the following statistics:
(Note: Please customize the OA statistics to simulate mass casualty event and capacity overload. Hospitals may also simulate the statistics to meet individual needs for exercise play.)

Statistics for the Operational Area (county):

Number of patients admitted with possible pneumonic plague: _____

Number of patients treated and triaged to home with symptomatic care, including mild symptoms, the worried well and pre-symptomatic patients: _____

Number of patients waiting to be seen: _____

Estimated number of persons that may require mass prophylaxis: _____

Number of deceased: _____

Healthcare resources within the community and operational area have been severely taxed and hospital and clinic are at maximum capacity. Physicians in the emergency department, clinics and medical offices, as well as EMS providers, are requesting information and treatment recommendations for the presenting symptoms of the patients that continue to flow into the system.

Information and recommendations being requested include:

- ✓ A case definition
- ✓ Proper isolation for patients presenting with suspected or probable symptoms
- ✓ Personal protective precautions for healthcare staff and first responders
- ✓ Recommended treatment plan

Important questions for the healthcare organization:

Now that *Yersinia pestis* has been identified:

- ☐ How do you identify patients seen in previous days before the biological agent was identified?
- ☐ How do you identify exposed staff?

- ☐ Who within your community/OA can provide your organization with the information and recommendations as listed above?
- ☐ How is this information disseminated to healthcare providers?
- ☐ How is this information disseminated to the public, including media?

4:00 p.m. Healthcare Provider Status

The hospital and clinic emergency plan is activated and the internal emergency operations center (EOC) opened. The county EOC has been activated and the medical and health branch, including the Medical and Health Operational Area Coordinator (MHOAC) continues to call for status reports, bed availability and critical issues.

The intensive care unit(s) within the hospital are at capacity and there are no additional Intensive Care Unit (ICU) beds. The emergency department (ED) is holding a number ____ (insert appropriate number of ED patients to increase strain on resources) of patients awaiting inpatient beds, including ICU, telemetry and medical surgical and negative pressure isolation rooms.

The influx of patients presenting to the ED continues in a steady stream, overwhelming resources, including staff (all levels of healthcare providers), lack of ED space, patient care equipment (gurneys, oximeters, ventilators, oxygen sources) and supplies (medications, patient care supplies) and personal protective equipment (N-95 respirator).

EMS is reporting an increased volume of 911 calls with chief complaint of shortness of breath, cough and fever, requiring transport to the hospital. The hospitals have been on and off diversion; however, now all hospitals are reporting closed status, therefore all hospitals are open. With the volume of 911 calls requiring ambulance transport and high ED and inpatient censuses, EMS providers are greatly delayed in delivering the patient and transferring the care of the patient to the hospital staff upon arrival, resulting in decreased availability of EMS responders to 911 calls.

Clinics are reporting large numbers of patients presenting with complaints of respiratory symptoms and do not have the resources to triage the patients. Patients with severe symptoms must be held in the clinic for long periods of time due to high patient census in the ED and lack of EMS transporters.

Local public health has declared a public health emergency and has determined that mass prophylaxis clinics should be activated to treat the public. Planning for this begins within the health department. Local public health releases alerts to the media to inform and educate the public about the disease symptoms, prevention, when to seek medical care and the availability of mass prophylaxis clinics.

4:30 p.m.

Local public health has announced the case definition for *Yersinia pestis* presenting as pneumonic plague. The case definition and treatment recommendations are:

- Contact with high risk area or person
- High fever (>101.5F)
- Rapid onset of respiratory illness (cough, hemoptysis, shortness of breath)
- Characteristic rash
- Tachycardia, hypotension, sepsis, sudden death
- Chest x-ray findings consistent with pneumonia (bilateral lobar infiltrates)
- Blood and/or sputum cultures positive for gram negative rods
- Serological confirmation of *Yersinia pestis* (DFA)

4:30 p.m.

A van pulls up to the ED ambulance bay with 10 children (all under age 12) and three adults having just returned from a camping trip. They had attended the concert before going camping. As they were returning from the trip, they heard about the plague outbreak on the radio and decided to come immediately to the ED. Five of them are complaining of cough, fever, malaise and abdominal pain. One adult has hemoptysis that began on Wednesday afternoon and one child has diarrhea. They developed symptoms on Tuesday night and have been getting worse and require immediate medical intervention. Five of the 13 people require hospitalization, further stressing already overwhelmed resources.

Considerations for healthcare providers:

- ☐ **What isolation control precautions have been taken for providers in all settings, including the hospital ED and inpatient units, clinics and EMS/Ambulance providers?**
- ☐ **What type of mask is required for staff caring for infectious patients? Is the N-95 Respirator required or can the staff be protected with standard masks? Who could provide this information to you in your community or from within hospital resources?**
- ☐ **Has triage been established to immediately isolate patients presenting with suspicious symptoms from the general population in hospitals and clinics?**
- ☐ **Has triage, support and education been established for the “worried well” presenting to the ED, clinics, medical offices and calling EMS providers?**

Healthcare staff, ancillary staff, physicians and EMS providers are beginning to call in sick for the upcoming shifts. While the majority of callers do not report an illness, the staff are anxious and have concerns for themselves and their family members should they be exposed to infectious patients in the course of their duties. Staffing has become critically short and is not anticipated to improve.

The hospital laboratory staff is asking what to do with an overwhelming number of sputum and blood specimens that they are receiving for processing. The lab manager reports this situation as critical and it must be addressed immediately.

Considerations for healthcare providers:

- ☐ **What other resources are available to your hospital lab to assist with specimen processing?**

High census plans are activated and all patients assessed for possible discharge or transferred, all elective surgeries and procedures are cancelled (patients have also been calling the hospitals and outpatient surgery clinics to cancel their surgeries because of fear of coming to the hospital).

To respond to the surge of patients, plans to augment staff and maximize current staffing resources are activated, including:

- ✓ Activation of call-back of staff
- ✓ Alteration of shift times, including implementation of 12-16-hour shifts
- ✓ Pre-scheduling staff to alternate shifts (a.m., p.m., noc) to maximize allocation of current resources and ensure 24-hour-a-day staffing

Considerations and possible actions:

- ❑ Local public health can assist with risk communication messages for the staff and the public to provide information, home care instructions and decrease public anxiety.
- ❑ Has the internal public information officer (PIO) and/or liaison officer developed media releases in collaboration with local public health and other healthcare facilities and created a PIO plan?
- ❑ Has critical incident stress management (CISM) planning and measures been instituted within the healthcare facility?
- ❑ What is the procedure for the healthcare organization/facility to mobilize internal CISM resources to support staff and for contacting local public health and mental health providers for assistance?
- ❑ Has mass prophylaxis for healthcare organization staff (hospital, clinic, EMS) and their families been considered in-house?
- ❑ Does your facility have the plans and resources needed to provide proper antibiotic prophylaxis for staff, their families and current patients?
- ❑ Who in the OA can be contacted to assist with healthcare staffing augmentation for the facilities? (MHOAC can be contacted)

The decision is made within the hospitals to designate a “wing” or area within the facility to cohort the possibly infectious patients. The following should be considered when designating an isolation area:

Considerations for healthcare providers:

- ❑ In consultation with the engineering department and infection control, where should the designated isolation area be established?
 - Patient care area
 - Conversion of a non-acute patient care area
 - Isolating patients in alternate care site outside of the hospital facility
- ❑ How can the Heating, Ventilation and Air Conditioning (HVAC) be controlled in the designated area to ensure respiratory isolation?
- ❑ What special considerations should be taken for the designated area?
 - Security
 - Staff assignment and protection
 - Traffic flow and restriction of personnel, families and friends

EMS has been transporting potentially infectious patients to the hospitals from homes and clinics across the community.

Considerations for healthcare providers:

- ❑ What procedures currently exist or must be implemented to decontaminate the ambulances between transports?
- ❑ What measures have been taken to protect the ambulance staff during patient assessment and transport?
- ❑ Are alternate care sites available for EMS to transport non-acute patients to instead of the acute care facility?
- ❑ Has mass prophylaxis for ambulance staff been arranged, and how is this information provided to the staff?
- ❑ What measures have been taken to increase staffing and the numbers of available ambulance units in service to accommodate the surge of patients?

5:00 p.m.

Local public health has established mass prophylaxis clinics in the following locations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Public alerts are broadcasted on all media, including television, radio and neighborhood meetings to inform the public and decrease anxiety. The local and national media are “camped out” at hospitals and the health department waiting for updates and becoming restless. The media have obtained information that the federal Centers for Disease Control and Prevention (CDC) are enroute and this increases the reports of biological terrorism in the media.

A press conference is scheduled for 6:30 p.m. with the public health officer, appropriate hospital and clinic representatives and local government officials.

Considerations and decisions:

- ☐ **What community or governmental agencies should participate in the press conferences? (Public health, hospital officials, local government, physicians)**
- ☐ **Who is the most appropriate person(s) to represent the healthcare facility at the press conference(s) and who makes this decision?**
- ☐ **How often should the press conferences be scheduled?**
- ☐ **Where should the press conferences be convened within the community?**
- ☐ **Who is the “lead” agency for the press conferences?**
- ☐ **What steps have been taken to ensure a consistent message among the healthcare community and all levels of government agencies/officials?**

5:45 p.m.

The hospitals, clinics and EMS providers are experiencing a shortage of equipment, supplies and facilities to care for patients. The shortages will be critical within 12 hours, including the following essential items:

N-95 Masks and other respiratory protective equipment
Ventilators
Oxygen tents to accommodate pediatric patients.
Antibiotics
Isolation facilities
Morgue facilities
Beds, gurneys, cots
Healthcare providers and staff support personnel

Hospitals, clinics, EMS and local public health construct contingency plans to address the upcoming critical shortages. Vendors are contacted to provide the additional supplies and equipment, but the vendors state that they will not deliver to the facility due to possible exposure of the delivery personnel.

Many patient deaths have been reported at the hospitals and the hospital morgue resources have reached capacity. The deaths are considered medical examiner's (coroner's) cases and potential evidence in a biological terrorism incident.

Considerations and possible actions:

- ❑ **Activate current processes and procedures to procure essential resources needed currently and within 12 hours?**
- ❑ **If no processes or procedures exist, what possible actions and plans can be taken to procure the resources?**
- ❑ **Can vendors be protected from exposure or provided prophylaxis to ensure delivery of needed resources?**
- ❑ **What resources and mechanisms are available to procure the needed supplies and equipment and who or what agency is contacted to provide those resources?**
 - **Intra-hospital resources**
 - **Inter-hospital resources**
 - **Community resources, including city and county**
 - **County resources, including the MHOAC in the EOC**
 - **Others**
 - **What are the proper channels of communication and who or what agency is contacted to obtain those resources**
- ❑ **What non-medical resources may be needed in the event? (i.e. security, law enforcement, sanitation, water, transportation)**

6:30 p.m.

The press conference begins.

6:45 p.m.

The press conference has spurred an overwhelming number of phone calls, both landline and cellular coming into and going out of the community. Local phone lines and cell sites are unable to accommodate the surge of calls and the phone systems go down. The hospitals, clinics, EMS providers and public health and county EOC are unable to place or receive calls.

Auxiliary Communication Systems (ACS) plans are activated. Local ACS members respond to provide critical communications as per current plans and procedures. If no plans or procedures exist, what emergency plans can be instituted to address the communication crisis?

7:00 p.m.

Local, state and federal law enforcement are arriving at the healthcare facilities and local health department. They are requesting to immediately interview staff, patients and families and to take possession of any evidence, including medical records.

- ✓ What issues does this pose to the healthcare facility, staff, patients, local public health and others?
- ✓ What policies and procedures are in place to guide and direct staff when handling these requests?
- ✓ If no policies currently exist, what emergency planning can be done to address these issues?
- ✓ How will law enforcement personnel interviewing patients be oriented to personal protection/isolation precautions?

7:15 p.m.

Phone service has been reestablished in the area. However, the phone company has stated that service may be intermittent due to volume. What decisions should be made about maintaining the ACS communication functions?

7:30 p.m.

All facilities, agencies and providers report status to the OA. The OA and EOC compile the reports, enter information into RIMS and place mission requests as appropriate.

7:45 p.m.

The Regional Emergency Operations Center (REOC) begins to receive reports from the OA and relays the information and resource requests to the Joint Emergency Operations Center (JEOC) and the State Operations Center.

8:00 p.m. THE EXERCISE ENDS

**Your logo
Or
Letterhead
Here**

**Sample
Public Information Officer
Media Advisory**

**Statewide Medical and Health Disaster Exercise
November 13, 2003**

Date: November XX, 2003

Contact: Jane Doe
(XXX) XXX-XXXX

- What:** California is conducting its fifth annual Statewide Medical & Health Disaster Exercise. Many hospitals, ambulance providers, public health and local government across the state will voluntarily participate in the exercise. The scenario for the exercise is a biological event with *Yersinia pestis* (or plague) and exercises the response of healthcare providers and governmental agencies to manage the influx of large numbers of ill and infectious patients. Last year nearly 400 healthcare facilities, more than 50 ambulance providers and nearly every county in California participated in the exercise.
- When:** Thursday, November 13, 2003, from 4:00 p.m. to 8:00 p.m.
- Where:** In hospitals and other healthcare provider organizations, public health ambulance services and local government agencies throughout the State of California.
- Who:** Exercise planners and supporters of this exercise include the Emergency Medical Services Authority; Department of Health Services; State, Regional and Local Office of Emergency Services; Office of Statewide Health Planning and Development; California Healthcare Association; Regional Hospital Associations; Auxiliary Communications Systems (ACS) volunteers; and hospitals and health systems.
- Background:** Participating in this exercises will help California communities be better prepared to respond to an actual disaster, should one occur. Hospital participation in this exercise also qualifies as a formal disaster drill with an influx of patients as defined by JCAHO.



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

INTENT TO PARTICIPATE

Please complete this form to indicate your intent to participate in the exercise.

**FAX THIS FORM TO THE OPERATIONAL AREA (COUNTY) MEDICAL/HEALTH EXERCISE
CONTACT (LISTED IN PAGE 42)
BY FRIDAY, SEPTEMBER 12, 2003.**

Type of Provider: ☐ Hospital ☐ Healthcare Facility ☐ Ambulance ☐ LEMSA
☐ ACS ☐ Public Health ☐ Other: _____

Name of
Facility or Provider: _____

Address: _____

City: _____ Zip: _____

County: _____

Exercise Coordinator or Contact: _____

Telephone #: _____ Fax #: _____

E-mail: _____

There are many levels of participation in the November 13 exercise, including:

- ☐ Full-scale exercise
- ☐ Functional exercise (See Glossary for exercise definitions)
- ☐ Table top exercise
- ☐ Communications exercise
- ☐ Other (specify): _____

Please complete this form for each healthcare facility, ambulance provider or entity participating in the exercise.

If you are a multiple facility or multi-campus facility,
complete **one "Intent to Participate" Form for each individual facility** participating.

The form may be duplicated for this purpose.



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

OPERATIONAL AREA INTENT TO PARTICIPATE

**The Medical/Health Exercise Contact will complete this form and fax to your
 Regional Disaster Medical/Health Specialist (listed on page 47)
 by FRIDAY, SEPTEMBER 26, 2003.**

Operational Area (County): _____

Operational Area Medical/Health
Exercise Contact Name: _____

Address: _____

City: _____ Zip: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Operational Area Agency	Intent to Participate in the Operational Area Exercise (Check One Column)		
	Yes, Will Participate	No, Will Not Participate	
Local Emergency Medical Services Agency			
Local Health Officer/Public Health			
Operational Area Disaster Medical/Health Coordinator			
Local Office of Emergency Services			
Auxiliary Communications Systems			
Other- Specify:			
Operational Area Participants	Total number in County	Yes, will Participate (Enter Number Participating)	No, Will Not Participate
Hospitals:			
Acute Care			
Other Healthcare facilities (SNF)			
Psychiatric Hospitals, facilities			
Clinics			
Other (specify):			
Ambulance Providers and Agencies			
Other- Specify:			
Other- Specify:			
Other- Specify:			
Other- Specify:			
Other- Specify:			

Fax this form to the Regional Disaster Medical/Health Specialist (Listed on pages 47) by September 26, 2003.



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

**HEALTHCARE FACILITY AND PROVIDER
MASTER ANSWER SHEET**

**Complete this Master Answer Sheet for responses to the Healthcare Facility/Provider
Exercise Evaluation Questions and mail only this page to the address below.**

Hospital/Healthcare Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the single best answer to each question.

1. a b c d e f g

8. a b c d

2. a b c d e f g h

9. a b c

3. a b c d

10. a b c

4. a b c

11. a b c

5. a b c

12. Comments

6. a b c d

7. a b c

Please write comments, suggestions or thoughts about the exercise on the reverse side of this answer sheet, attaching additional pages as needed. We appreciate your comments!

Mail completed answer sheet by NOVEMBER 28, 2003, to:

**California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814
Attn: Disaster Exercise**



**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003**

HEALTHCARE FACILITY AND PROVIDER EXERCISE EVALUATION QUESTIONS

This form is to be completed by the participating healthcare facility/provider.

Please use the attached **Master Answer Sheet** when recording your responses. Be sure to complete every question before submitting the Master Answer Sheet (page 20) to the EMS Authority. Certificates for Participation will be provided only upon receipt of the 2003 Exercise Participation Evaluation Master Answer Sheet.

1. Please circle the single best answer that describes in which OES Mutual Aid Region your facility is located (Listed on page 47).
 - A. Region I
 - B. Region II
 - C. Region III
 - D. Region IV
 - E. Region V
 - F. Region VI
 - G. Don't Know

2. Circle the single best answer that describes your facility.
 - A. Acute care hospital with a basic or comprehensive emergency department
 - B. Acute care hospital with a stand-by emergency department
 - C. Acute care hospital with no emergency department
 - D. Psychiatric hospital
 - E. Specialty care hospital
 - F. Long-term care facility
 - G. Clinic
 - H. Other

3. Please indicate the level of participation of your facility during the exercise.
 - A. Full Scale Exercise
 - B. Functional Exercise
 - C. Tabletop Exercise
 - D. Communications Exercise

4. Did you activate your disaster plan during the exercise?
 - A. Yes
 - B. No
 - C. Don't Know

5. Does your disaster plan utilize the Hospital Emergency Incident Command System (HEICS)?
 - A. Yes
 - B. No
 - C. Please send my organization information on HEICS

HEALTHCARE FACILITY EXERCISE EVALUATION QUESTIONS (Continued)

6. Did your facility implement an alternate communication system (other than public telephone service) to reach the County Emergency Operations Center, nearby hospitals or “sister” hospitals?
 - A. Yes
 - B. No
 - C. Don’t know
 - D. N/A
7. Did your facility implement methods to respond to a large influx of patients and subsequent facility overcrowding?
 - A. Yes
 - B. No
 - C. Don’t know
8. How would you evaluate your facility’s response to the event and initiation of disaster plan?
 - A. Excellent, no changes needed in the disaster plan
 - B. Good, minor changes in the system/disaster plan identified
 - C. Fair, moderate changes needed in the system/disaster plan identified
 - D. Needs improvement, substantial disaster plan review/changes identified
9. In general, were you satisfied with the November 13 statewide exercise?
 - A. Yes
 - B. No
 - C. Don’t know

In the past, the annual statewide exercise is conducted from 8:00 a.m. until 12:00 p.m., but this year the Exercise Planning Committee scheduled the annual Statewide Exercise from 4:00 p.m. to 8:00 p.m. Please provide us with your feedback.

10. Would your facility participate in another statewide “off hours” exercise in the future?
 - A. Yes (If yes, please answer question number 11)
 - B. No (If no, please skip to question number 12)
 - C. Don’t know
11. The facility would participate in a statewide exercise conducted in the following hours: (Please check all hours your facility would consider participating in)
 - A. P.M. Shift hours (3 p.m. to 11 p.m.)
 - B. Night Shift hours (11 p.m. to 7 a.m.)
 - C. Weekend days

12. Additional Comments and Recommendations?

Please write additional comments on the back of the Master Answer Sheet and attach additional pages as needed. We very much appreciate your feedback!

Thank you for your participation in this survey.

**Please mail the
COMPLETED MASTER ANSWER SHEET
by
November 28, 2003,
to:**

**California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814-7043**

Attn: Disaster Exercise



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

AMBULANCE PROVIDER
MASTER ANSWER SHEET

Complete this Master Answer Sheet for responses to the Ambulance Provider Exercise Evaluation Questions and mail only this page to the address below.

Ambulance Provider Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the single best answer to each question.

- | | |
|---------------------------------|---------------------|
| 1. a b c d e f g | 9. a b c d |
| 2. a b c d | 10. a b c d |
| 3. a b c d e | 11. a b c |
| 4. a b c d | 12. a b c |
| 5. a b c | 13. Comments |
| 6. a b c | |
| 7. a b c d | |
| 8. a b c | |

Please write comments, suggestions or thoughts about the exercise on the reverse side of this answer sheet, attaching additional pages as needed. We appreciate your comments!

Mail completed answer sheet by NOVEMBER 28, 2003, to:

California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814

Attn: Disaster Exercise



**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003**

AMBULANCE PROVIDER EXERCISE EVALUATION QUESTIONS
This form is to be completed by the participating ambulance provider.

Please use the **Master Answer Sheet** (page 24) for Ambulance Providers when recording your responses. Be sure to complete every question before submitting the answer sheet to the EMS Authority. Certificates for Participation will be provided only upon receipt of the 2003 Exercise Participation Evaluation Master Answer Sheet.

1. Circle the single best answer that describes in which OES Mutual Aid Region your service is located (Listed on page 47).
 - A. Region I
 - B. Region II
 - C. Region III
 - D. Region IV
 - E. Region V
 - F. Region VI
 - G. Don't Know

2. Please circle the single best answer that describes your service.
 - A. Basic Life Support
 - B. Advanced Life Support
 - C. Both A and B
 - D. Other (specify) _____

3. Circle the single best answer that describes your service.
 - A. Private business
 - B. Fire service affiliate
 - C. Special district or local government (other than fire service)
 - D. Hospital affiliate
 - E. Other (specify) _____

4. Circle the level of participation of your service during the exercise.
 - A. Full Scale Exercise
 - B. Functional Exercise
 - C. Tabletop Exercise
 - D. Communications Exercise

5. Did you activate your disaster plan during the exercise?
 - A. Yes
 - B. No
 - C. Don't know

AMBULANCE PROVIDER EXERCISE EVALUATION QUESTIONS (Continued)

6. Does your disaster plan utilize the Incident Command System (ICS)?
 - A. Yes
 - B. No
 - C. Don't know
7. Did you implement an alternative communication system, other than the telephone, to reach the ambulance crews, dispatch and hospitals during the exercise?
 - A. Yes
 - B. No
 - C. Don't know
 - D. N/A
8. Did you implement methods to respond to an increased call volume while hospitals were on diversion due to ED overcrowding and high inpatient census?
 - A. Yes
 - B. No
 - C. Don't know
9. How would you evaluate your service's response to the event and initiation of disaster plan?
 - A. Excellent, no changes needed in the disaster plan
 - B. Good, minor changes in the system/disaster plan identified
 - C. Fair, moderate changes needed in the system/disaster plan identified
 - D. Needs improvement, substantial disaster plan review and changes identified
10. In general, were you satisfied with the November 13 Statewide exercise?
 - A. Yes
 - B. No
 - C. Don't know
 - D. N/A

In the past, the annual statewide exercise is conducted from 8:00 a.m. until 12:00 p.m., but this year the Exercise Planning Committee scheduled the annual Statewide Exercise from 4:00 p.m. to 8:00 p.m. Please provide us with your feedback.

11. Would your facility participate in another statewide "off hours" exercise in the future?
 - A. Yes (If yes, please answer question number 12)
 - B. No (If no, please skip to question number 13)
 - C. Don't know
12. The facility would participate in a statewide exercise conducted in the following hours:
(Please check all hours your facility would consider participating in)
 - A. P.M. Shift hours (3 p.m. to 11 p.m.)
 - B. Night Shift hours (11 p.m. to 7 a.m.)
 - C. Weekend days

13. Additional Comments and Recommendations?

Please write additional comments on the back of the Master Answer Sheet and attach additional pages as needed. We very much appreciate your feedback!

Thank you for your participation in this survey.

**Please mail the
COMPLETED MASTER ANSWER SHEET
By
November 28, 2003,
to:**

**California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814**

Attn: Disaster Exercise



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

**EMERGENCY AND AUXILIARY COMMUNICATIONS SYSTEM PROVIDERS (ACS)
MASTER ANSWER SHEET**

**Complete this Master Answer Sheet for responses to the Emergency and ACS Exercise
Evaluation Questions and mail only this page to the address below.**

Organization Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the single best answer to each question.

1. a b c d e f g

8. a b c

2. a b c d

9. a b c

3. a b c

10. a b c

4. a b c

11. a b c d

5. a b c

12. a b c d

6. a b c

13. a b c

7. a b c

14. a b c

15. **Comments?**

Please write comments, suggestions or thoughts about the exercise on the reverse side of this answer sheet, attaching additional pages as needed. We appreciate your comments!

Mail completed answer sheet by NOVEMBER 28, 2003, to:

**California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814**

Attn: Disaster Exercise



**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003**

**EMERGENCY AND AUXILIARY COMMUNICATIONS SYSTEMS (ACS)
EXERCISE EVALUATION QUESTIONS**

This form is to be completed by each participating radio provider.

Please use the attached **Master Answer Sheet** (page 28) for Emergency and ACS Providers when recording your responses. Be sure to complete every question before submitting the answer sheet to the EMS Authority. Certificates for Participation will be provided only upon receipt of the 2003 Exercise Participation Evaluation Master Answer Sheet.

1. Circle the single best answer that describes in which OES Mutual Aid Region your organization is located (Listed on page 47).
 - A. Region I
 - B. Region II
 - C. Region III
 - D. Region IV
 - E. Region V
 - F. Region VI
 - G. Don't Know

2. Please circle the single best answer that describes your organization.
 - A. ACS
 - B. CARES
 - C. RACES
 - D. Other: (specify) _____

3. Did you activate your disaster plan during the exercise?
 - A. Yes
 - B. No
 - C. Don't know

4. Does your disaster plan utilize the Incident Command System (ICS)?
 - A. Yes
 - B. No
 - C. Don't know what ICS is.

5. Did you educate the hospitals and operators in your area about the frequencies, information packet and protocols pre-exercise?
 - A. Yes
 - B. No
 - C. Don't know

6. Did you coordinate and pre-exercise with local amateur radio operators on frequencies and protocols to use during the November 13 exercise?
 - A. Yes
 - B. No
 - C. Don't know

**EMERGENCY AND AUXILIARY COMMUNICATIONS SYSTEMS (ACS)
EXERCISE EVALUATION QUESTIONS (Continued)**

7. Did you transmit and receive information?
 - A. Yes
 - B. No
 - C. Don't know
8. Was the transmitted data received and accepted?
 - A. Yes
 - B. No
 - C. Don't know
9. Did you activate the regional/statewide network voice systems during the exercise?
 - A. Yes
 - B. No
 - C. Don't know
10. Were frequencies and channels open and available for transmission during the exercise?
 - A. Yes
 - B. No
 - C. Don't Know
11. How would you evaluate your organization's response to the event and initiation of the disaster plan?
 - A. Excellent, no changes needed in the disaster plan
 - B. Good, minor changes in the system/disaster plan identified
 - C. Fair, moderate changes needed in the system/disaster plan identified
 - D. Needs improvement, substantial disaster plan review and changes identified
12. In general, were you satisfied with the November 13 statewide exercise?
 - A. Yes
 - B. No
 - C. Don't know
 - D. N/A

In the past, the annual statewide exercise is conducted from 8:00 a.m. until 12:00 p.m., but this year the Exercise Planning Committee scheduled the annual Statewide Exercise from 4:00 p.m. to 8:00 p.m. Please provide us with your feedback.

13. Would your facility participate in another statewide "off hours" exercise in the future?
 - A. Yes (If yes, please answer question number 14)
 - B. No (If no, please skip to question number 15)
 - C. Don't know
14. The facility would participate in a statewide exercise conducted in the following hours:
(Please check all hours your facility would consider participating in)
 - A. P.M. Shift hours (3 p.m. to 11 p.m.)
 - B. Night Shift hours (11 p.m. to 7 a.m.)
 - C. Weekend days

15. Additional Comments and Recommendations?

Please write additional comments on the back of the Master Answer Sheet and attach additional pages as needed. We very much appreciate your feedback!

Thank you for your participation in this survey.

**Please mail the
COMPLETED MASTER ANSWER SHEET**

**By
November 28, 2003,
to:**

**California Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814**

Attn: Disaster Exercise



**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003**

Conducting the 2003 Exercise Tips for Hospitals

This year, the Medical and Health Disaster Exercise scenario is providing participants with an opportunity to expand their facility-wide exercise. Many times, the drills and tabletops conducted have focused on the emergency department and emergency services and have not impacted all units and/or departments in the facility. This year, the scenario focuses on the entire healthcare facility and its ability to manage a large influx of patients and address the allocation of scarce resources including staffing, inpatient beds and equipment, supplies and medications. The 2003 Medical and Health Exercise Planning Committee encourage hospitals to involve all units/departments and staff within the hospital to actively participate in the exercise and activate departmental emergency plans.

The exercise day begins on day four of a course of events following the *Yersinia pestis* (plague) exposure of a large number of people. Should this be an actual event, the hospital would be confronting these issues and coordinating efforts with other community hospitals and local response agencies (public health, EMS agency, OES, law enforcement, among others). When planning and executing your exercise, it is recommended that you begin the exercise with your hospital highly impacted and reaching a peak in managing scarce resources and overwhelming census and patient load.

There are different types of exercises that can be conducted including functional, full scale and tabletop (see glossary for definition of exercises, page 34). Each of these exercises can test your response and management of the event.

The following are some recommendations to achieve hospital-wide participation in the exercise:

- ❑ Activate the hospital Emergency Operations Center (EOC) and the Hospital Emergency Incident Command System (HEICS)/ or unified command sections to manage the event and address the policy issues as described in the scenario. Incorporate into the activation personnel who may not have previously played a role in the EOC, such as infectious disease practitioners, epidemiologists, Infection Control staff, occupational health staff and others.
- ❑ Activate high census plans in all departments and move “live” patients, “live” volunteer patients, or paper patients as appropriate to vacate beds and accept new patients.
- ❑ Mobilize the infectious disease practitioners/infection control department to assist in determining facility priorities, patient care management, staff protection and reporting to local public health.
- ❑ Select a department or unit within the facility that will be utilized to cohort infectious patients. (See glossary page 34 for definition of cohort). Task engineering to devise a plan to isolate the Heating, Ventilation and Air Conditioning (HVAC) system for this unit and task nursing to plan for setting up supplies and equipment and staffing the unit.
- ❑ Test the call back (staff notification) systems and lists, update lists and procedures as appropriate.

Tips for Hospitals

- ❑ Provide “on the spot” fit testing of the N-95 masks to ensure employee protection in caring for the infectious patients. The “fit testing” should include clinical and non-clinical support staff (housekeeping, dietary, engineering, security).
- ❑ Inventory all linen, nutritional supplies (food) and housekeeping materials to determine if additional quantities will be needed for the large patient influx and high patient census.
- ❑ Activate internal and external security plans and actually institute traffic control measures, visitor access and set up perimeter barricades, etc.
- ❑ Prepare a plan to “lock down” the facility defining under what authority, when and how a “lock down” would occur and when the “lock down” would be discontinued. Review the ability to maintain ongoing Emergency Department services in the event of a lock-down and the ability to receive ambulance traffic and walk-in patients.
- ❑ Activate the hospital’s auxiliary communications system (amateur radio) and test message sending and receiving.
- ❑ Implement hospital lab procedures to manage infectious blood specimens and cultures in large numbers, including staffing and processing. Mock up the proper packaging and secure shipping of specimens to the local public health laboratory through the Laboratory Response Network.
- ❑ Arrange for the influx of patients using “live” volunteer patients (or paper patients) coming through the Emergency Department as described in the scenario.
- ❑ Stage a convergence of volunteers into the facility offering clinical and non-clinical assistance with live persons (or paper volunteers). How will the facility deal with and manage these well-meaning volunteers presenting? How will their licensing and credentialing issues be dealt with?
- ❑ Assess quantities of pharmaceuticals (antibiotics) available in the facility to treat pneumonic plague.
- ❑ Develop or activate existing plans to provide prophylaxis to hospital staff. Determine priority of hospital staff treatment based on available antibiotics on site, distribution site(s) within the hospital, and tracking and follow-up for staff receiving prophylaxis.
- ❑ Institute procedures in business office and patient registration to manage an overwhelming number of patients and implement Hospital Information System/ Information Technology emergency policies and procedures to accommodate the business needs of the facility.
- ❑ Activate your media relations or public information officer to respond to multiple media calls for information and/or convergence of media into your facility.

These are only a few of the ideas to conduct a successful exercise that will engage and involve multiple units/departments in a hospital. Use your imagination and be creative in your planning for the 2003 Statewide Medical and Health Disaster Exercise!



State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 13, 2003

Glossary of Terms

Auxiliary Communications Services (ACS)	<p>The Auxiliary Communications Service (ACS) is an emergency communications unit that provides State and local government with a variety of professional unpaid [volunteer] skills, including administrative, technical and operational for emergency tactical, administrative and logistical communications. ACS works with agencies and cities within the Operational Area, neighboring governments and the State OES Region. Its basic mission is the emergency support of civil defense, disaster response and recovery with telecommunications resources and personnel.</p> <p><u>CARES:</u> California Amateur Radio Emergency Services CARES is specifically tasked to provide amateur radio communications support for the medical and health disaster response to state government.</p> <p><u>RACES:</u> Radio Amateur Civilian Emergency Services RACES is a local or state government program established by a civil defense official. It becomes operational by: 1) appointing a radio officer; 2) preparing a RACES plan; and 3) training and utilizing FCC licensed amateur radio operators. RACES, whether part of an ACS or as a stand alone unit, is usually attached to a state or local government's emergency preparedness office or to a department designated by that office, such as the sheriff's or communications department.</p>
Bioterrorism	<p>The intentional or threatened use of viruses, bacteria, fungi or toxins from living organisms to produce death or disease in humans, animals or plants.</p>
Cohorting	<p>Co-locating a group of persons (patients) experiencing similar symptoms or disease syndrome to provide medical care and/or isolation.</p>
Disease Surveillance	<p>In epidemiology and public health, the identification of index patients and their contacts; the detection of outbreaks and epidemics; the determination of the incidence and demographics of an illness; and the policy-making that may prevent further spreading of disease.</p>

Glossary of Terms

Droplet Transmission And Isolation	<p><u>Transmission:</u> Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing or talking and during the performance of certain procedures, such as suctioning and bronchoscopy. Transmission via large-particle droplets requires close contact between source and recipient persons because droplets do not remain suspended in the air and generally travel only short distances, usually three feet or less, through the air. Since droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission.</p> <p><u>Droplet Isolation:</u> Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least three feet between the infected patient and other patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open. Category IB</p>
Emergency	A condition of disaster or of extreme peril to the safety of persons and property caused by such conditions as air pollution, fire, flood, hazardous material incident, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestations or disease, an earthquake or volcanic eruption.
Emergency Management	The organized analysis, planning, decision making, assignment and coordination of available resources to the mitigation of, preparedness for, response to or recovery from emergencies of any kind, whether from man-made attack or natural sources.
Emergency Operations Center	A centralized location from which emergency operations can be directed and coordinated.
Epidemic	An infectious disease or condition that attacks many people at the same time in the same geographical area.
Epidemiology	The study of the distribution and determinants of health-related states and events in populations, and the application of this study to the control of health problems. Epidemiology is concerned with the traditional study of epidemic diseases caused by infectious agents, and with health-related phenomena.
Exposure Versus Contamination	<p><u>Exposure:</u> Subjected to, or exposed to, a contaminant in an unprotected or partially protected manner, but not necessarily contaminated by an agent.</p> <p><u>Contamination:</u> Contact with a hazardous or infective agent in an unprotected manner.</p>

Glossary of Terms

Exercise	<p><u>Functional:</u> The functional exercise is an activity designed to test or evaluate the capabilities of the disaster response system. It can take place in the location where the activity might normally take place, such as the command center or incident command post. It can involve deploying equipment in a limited, function-specific capacity. This exercise is fully simulated with written or verbal messages.</p> <p><u>Full Scale:</u> This type of exercise is intended to evaluate the operational capability of emergency responders in an interactive manner over a substantial period of time. It involves the testing of a major portion of the basic elements existing in the emergency operations plans and organizations in a stress environment. Personnel and resources are mobilized.</p> <p><u>Tabletop:</u> An exercise that takes place in a classroom or meeting room setting. Situations and problems presented in the form of written or verbal questions generate discussions of actions to be taken based upon the emergency plan and standard emergency operating procedures. The purpose is to have participants practice problem solving and resolve questions of coordination and assignment in a non-threatening format, under minimal stress.</p> <p><u>Communications:</u> The communications exercise is designed to test and evaluate communication systems, including lines and methods of communicating during a disaster. Alternative communication systems can also be tested, including amateur radio, cell and satellite systems, among others.</p>
Hospital Emergency Incident Command System (HEICS)	<p>HEICS is an emergency management system that employs a logical, unified management (command) structure, defined responsibilities, clear reporting channels and a common nomenclature to help unify hospitals with other emergency responders. Information on HEICS can be obtained through the California EMSA at 916-322-4336 or on the Website at www.emsa.ca.gov.</p>
Incident Command System (ICS)	<p>The nationally used standardized on-scene emergency management concept is specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demand of single or multiple incidents without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, with the responsibility of managing resources to effectively accomplish stated objectives pertinent to an incident.</p>

Glossary of Terms

Fit Testing	All respirators that rely on a mask-to-face seal need to be annually checked with either qualitative or quantitative methods to determine whether the mask provides an acceptable fit to a wearer. The qualitative fit test procedures rely on a subjective sensation (taste, irritation, smell) of the respirator wearer to a particular test agent while the quantitative fit test measures face seal leakage. The relative workplace exposure level determines what constitutes an acceptable fit and which fit test procedure is required. (OSHA 29 CFR 1910.139)
Incubation Period	The interval between exposure to infection and the appearance of the first symptom.
Index Patient	An instance of a disease or a genetically determined condition that is discovered first and leads to the discovery of others in a family or population.
Isolation	The physical separation of infected or contaminated organisms from others to prevent or limit the transmission of disease. In contrast, quarantine applies to restriction on healthy contacts of an infectious agent.
Joint Emergency Operations Center (JEOC)	A unified operations center established by the State Emergency Medical Services Authority and Department of Health Services to manage the State-level medical and health response to disasters, including the use of state resources.
Long-Term Care Facilities	A collective term for healthcare facilities designated for the care and treatment of patients or residents requiring rehabilitation or extended care for chronic conditions. The Department of Health Services, Licensing and Certification Division licenses these facilities.
Mass Prophylaxis	The provision of medications and/or vaccines to large numbers of the public to prevent or treat an infectious disease.
Medical and Health Operational Area Coordinator (MHOAC) (Formerly known as OADMHC)	The OAC is responsible for coordinating mutual aid resource requests, facilitating the development of local medical/health response plans and implementing the medical/health plans during a disaster response. During a disaster, the OAC directs the medical/health branch of the Operational Area EOC and establishes priorities for medical/health response and requests. This coordinator was formerly known as the Operational Area Disaster Medical/Health Coordinator.
N-95 Mask	See "Respirator, N-95"
Operational Area	An intermediate level of the State emergency services organization, consisting of a county and all political subdivisions within the county.

Glossary of Terms

Pandemic	A disease affecting the majority of the population of a large region, such as dental caries or periodontal disease, or one that is epidemic at the same time in many different parts of the world.
Plague	A disease caused by <i>Yersinia pestis</i> (<i>Y. Pestis</i>), a bacterium found in rodents and their fleas in many areas around the world. Plague may present in two forms: Bubonic, which is spread by flea bites and results in swollen, tender lymph nodes called buboes; and Pneumonic, which affects the lungs and is transmitted when a person breathes in <i>Y. Pestis</i> particles in the air.
Quarantine	The period during which free entry to a country by humans, animals, plants or agricultural products is prohibited in order to limit the spread of potentially infectious diseases; the period of isolation from public contact after contracting a contagious disease, such as rabies. Complete quarantine is the limitation of the freedom of movement of healthy persons or domestic animals that have been exposed to a communicable disease for a period of time equal to the longest incubation period of the disease, in such a manner as to prevent effective contact with those not so exposed.
Regional Emergency Operations Center (REOC)	The Regional Emergency Operations Center (REOC) is the first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the operational areas and coordinates with the State Operations Center.
Respirators N-95	Recent CDC infection control guidance documents provide recommendations that health care workers protect themselves from diseases potentially spread through the air (such as Severe Acute Respiratory Syndrome or Tuberculosis) by wearing a fit-tested respirator at least as protective as a National Institute for Occupational Safety and Health (NIOSH)-approved N-95 respirator. An N-95 respirator is one of nine types of disposable particulate respirators. Particulate respirators are also known as "air-purifying respirators" because they protect by filtering particles out of the air you breathe. Workers can wear any one of the particulate respirators for protection against diseases spread through the air- if they are NIOSH approved and if they have been properly fit-tested and maintained. NIOSH-approved disposable respirators are marked with the manufacturer's name, the part number (P/N), the protection provided by the filter (e.g. N-95) and "NIOSH."
Standardized Emergency Management System (SEMS)	SEMS is the emergency management system identified by Government code 8607 for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the Incident Command System and is intended to standardize response to emergencies in California.
State Operations Center (SOC)	The SOC is established by OES to oversee, as necessary, the REOC, and is activated when more than one REOC is opened. The SOC establishes overall response priorities and coordinates with federal responders.



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Frequently Asked Questions (FAQ) About Plague

CDC Website at <http://www.bt.cdc.gov/agent/plague/faq.asp>

What is plague?

Plague is a disease caused by *Yersinia pestis* (*Y. pestis*), a bacterium found in rodents and their fleas in many areas around the world.

Why are we concerned about pneumonic plague as a bioweapon?

Yersinia pestis used in an aerosol attack could cause cases of the pneumonic form of plague. One to six days after becoming infected with the bacteria, people would develop pneumonic plague. Once people have the disease, the bacteria can spread to others who have close contact with them. Because of the delay between being exposed to the bacteria and becoming sick, people could travel over a large area before becoming contagious and possibly infecting others. Controlling the disease would then be more difficult. A bioweapon carrying *Y. pestis* is possible because the bacterium occurs in nature and could be isolated and grown in quantity in a laboratory. Even so, manufacturing an effective weapon using *Y. pestis* would require advanced knowledge and technology.

Is pneumonic plague different from bubonic plague?

Yes. Both are caused by *Yersinia pestis*, but they are transmitted differently and their symptoms differ. Pneumonic plague can be transmitted from person to person; bubonic plague cannot. Pneumonic plague affects the lungs and is transmitted when a person breathes in *Y. pestis* particles in the air. Bubonic plague is transmitted through the bite of an infected flea or exposure to infected material through a break in the skin. Symptoms include swollen, tender lymph glands called buboes. Buboes are not present in pneumonic plague. If bubonic plague is not treated, however, the bacteria can spread through the bloodstream and infect the lungs, causing a secondary case of pneumonic plague.

What are the signs and symptoms of pneumonic plague?

Patients usually have fever, weakness and rapidly developing pneumonia with shortness of breath, chest pain, cough and sometimes bloody or watery sputum. Nausea, vomiting and abdominal pain may also occur. Without early treatment, pneumonic plague usually leads to respiratory failure, shock and rapid death.

How do people become infected with pneumonic plague?

Pneumonic plague occurs when *Yersinia pestis* infects the lungs. Transmission can take place if someone breathes in *Y. pestis* particles, which could happen in an aerosol release during a bioterrorism attack. Pneumonic plague is also transmitted by breathing in *Y. pestis* suspended in respiratory droplets from a person (or animal) with pneumonic plague. Respiratory droplets are spread most readily by coughing or sneezing. Becoming infected in this way usually requires direct and close (within six feet) contact with the ill person or animal. Pneumonic plague may also occur if a person with bubonic or septicemic plague is untreated and the bacteria spreads to the lungs.

Does plague occur naturally?

Yes. The World Health Organization reports 1,000 to 3,000 cases of plague worldwide every year. An average of five to 15 cases occur each year in the western United States. These cases are usually scattered and occur in rural to semi-rural areas. Most cases are of the bubonic form of the disease. Naturally occurring pneumonic plague is uncommon, although small outbreaks do occur. Both types of plague are readily controlled by standard public health response measures.

Can a person exposed to pneumonic plague avoid becoming sick?

Yes. People who have had close contact with an infected person can greatly reduce the chance of becoming sick if they begin treatment within seven days of their exposure. Treatment consists of taking antibiotics for at least seven days.

How quickly would someone get sick if exposed to plague bacteria through the air?

Someone exposed to *Yersinia pestis* through the air—either from an intentional aerosol release or from close and direct exposure to someone with plague pneumonia—would become ill within one to six days.

Can pneumonic plague be treated?

Yes. To prevent a high risk of death, antibiotics should be given within 24 hours of the first symptoms. Several types of antibiotics are effective for preventing and curing the disease. Available oral medications are tetracycline (such as doxycycline) or fluoroquinolone (such as ciprofloxacin). For injection or intravenous use, streptomycin or gentamicin antibiotics are used. Early in the response to a bioterrorism attack, these drugs would be tested to determine which is most effective against the particular weapon that was used.

Would enough medication be available in the event of a bioterrorism attack involving pneumonic plague?

National and state public health officials have large supplies of drugs needed in the event of a bioterrorism attack. These supplies can be sent anywhere in the United States within 12 hours.

What should someone do if they suspect they or others have been exposed to plague?

Get immediate medical attention: To prevent illness, a person who has been exposed to pneumonic plague must receive antibiotic treatment without delay. If an exposed person becomes ill, antibiotics must be administered within 24 hours of their first symptoms to reduce the risk of death. Notify authorities: Immediately notify local or state health departments so they can begin to investigate and control the problem right away. If bioterrorism is suspected, the health departments will notify the CDC, FBI and other appropriate authorities.

How can someone reduce the risk of getting pneumonic plague from another person or giving it to someone else?

People having direct and close contact with someone with pneumonic plague should wear tightly fitting disposable surgical masks. Patients with the disease should be isolated and medically supervised for at least the first 48 hours of antibiotic treatment. People who have been exposed to a contagious person can be protected from developing plague by receiving prompt antibiotic treatment.

How is plague diagnosed?

The first step is evaluation by a health worker. If the health worker suspects pneumonic plague, samples of the patient's blood, sputum or lymph node aspirate are sent to a laboratory for testing. Once the laboratory receives the sample, preliminary results can be ready in less than two hours. Confirmation will take longer, usually 24 to 48 hours.

How long can plague bacteria exist in the environment?

Yersinia pestis is easily destroyed by sunlight and drying. Even so, when released into air, the bacterium will survive for up to one hour, depending on conditions.

Is a vaccine available to prevent pneumonic plague?

Currently, no plague vaccine is available in the United States. Research is in progress, but we are not likely to have vaccines for several years.

Other Resources

CDC Website, "Facts About Plague"

<http://www.bt.cdc.gov/documentsapp/FactSheet/Plague/About.asp>

National Institute of Mental Health

"Information About Coping With Traumatic Events/Terrorism"

<http://www.nimh.nih.gov/outline/traumatic.cfm>



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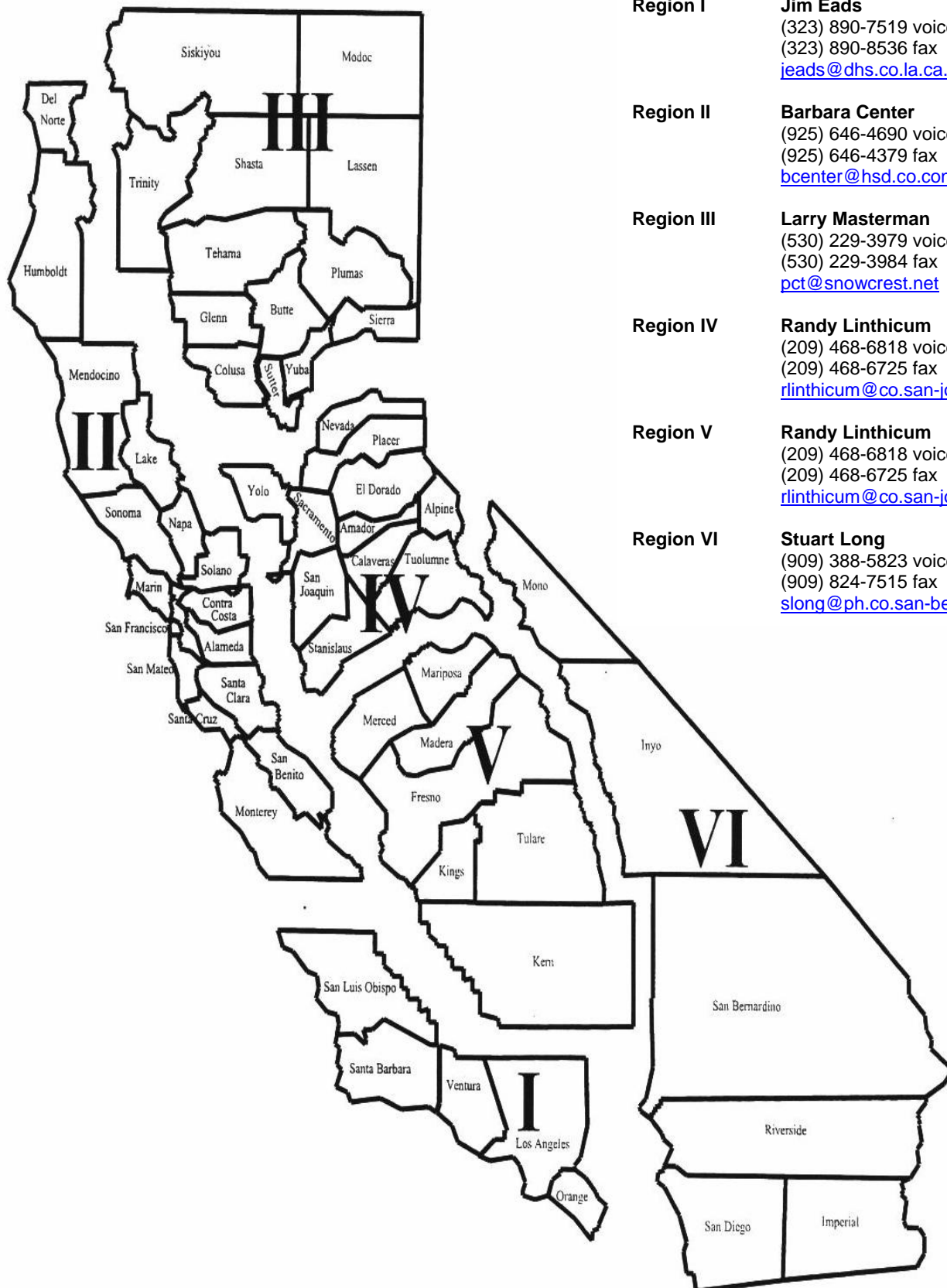
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**State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
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The Emergency Medical Services Authority would like to thank the Disaster Exercise Planning Group members for their contribution to the 2003 Statewide Medical and Health Disaster Exercise Guidebook and planning process.

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